STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G444	A. BUILDING 00 B. WING	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	902 N MUESSING RD INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	This visit was for a fundamental recertification and state licensure survey. Survey dates: July 9, 10, and 11, 2012. Facility number: 000958 Provider number: 15G444 AIMS number: 100235250 Surveyor: Brenda Nunan, RN, CDDN, Public Health Nurse Surveyor III These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review was completed on 7/15/12 by Tim Shebel, Medical Surveyor III	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G444	A. BUILDING 00 B. WING	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	902 N MUESSING RD INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility failed to implement its policy and procedures to immediately report an allegation of client abuse to the administrator and/or state agencies (client #4 and discharged client #7). Findings include: The facility's policy and procedures were reviewed on 07/09/2012 at 11:55 a.m. The facility's policy, titled, "Preventing Abuse and Neglect," dated 12/15/2011, indicated, "..."Abuse" means the following: 1. Intentional or willful infliction of physical injury...Under this policy,, reports of "concerns" or other minimizations of abuse/neglect,...shall be considered allegations and shall be treated accordingly...Immediately upon being notified of the incident, the Residential Director (or on-call Residential Director) must:...3. Report the incident to BDDS (Bureau of Developmental Disability Services)...." The facility's reportable incident reports and internal investigations from 10/12/2011-06/22/2012 were reviewed on 07/09/2012 at 12:05 p.m. An	W0149	In the event that an incident occurs in which the health and safety of the individual is jeopardized or there is an allegation of abuse, mistreatment or neglect suspected, a report will be made to state agencies including the Indiana Division of Disability and Rehabilitative Services and the Bureau of Developmental Disabilities. The Residential Director received training on the incidents which are required to be reported to these state agencies on 7/19/12. Person Responsible: Area Director and Residential Director	08/10/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G444	A. BUILDING 00 B. WING	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	902 N MUESSING RD INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"INVESTIGATION SUMMARY FORM," dated 05/31/2012, indicated, "...On 5/31/12 there was an incident of consumer to consumer aggression in which [client #7] struck [client #4] several times in the back....Findings: 1. [Client #7] did hit [client #4] while getting on the van after work at Shares...." During an interview on 07/09/2012, Area Director (AD) #1 indicated an Indiana Division of Disability and Rehabilitative Services Incident Report/Bureau of Developmental Disabilities incident report had not been filed for the client abuse on 05/31/2012. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G444	A. BUILDING 00 B. WING	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	902 N MUESSING RD INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on interview and record review for 1 of 1 allegation of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to immediately report client to client abuse to the administrator and/or other state agencies (client #4 and discharged client #7). Findings include: The facility's reportable incident reports and internal investigations from 10/12/2011-06/22/2012 were reviewed on 07/09/2012 at 12:05 p.m. An "INVESTIGATION SUMMARY FORM," dated 05/31/2012, indicated, "...On 5/31/12 there was an incident of consumer to consumer aggression in which [client #7] struck [client #4] several times in the back....Findings: 1. [Client #7] did hit [client #4] while getting on the van after work at Shares...." During an interview on 07/09/2012, Area Director (AD) #1 indicated an Indiana Division of Disability and Rehabilitative Services Incident Report/Bureau of	W0153	In the event that an incident occurs in which the health and safety of the individual is jeopardized or there is an allegation of abuse, mistreatment or neglect suspected, a report will be made to state agencies including the Indiana Division of Disability and Rehabilitative Services and the Bureau of Developmental Disabilities. The Residential Director received training on the incidents which are required to be reported to these state agencies 7/19/12. Persons Responsible: Residential Director and Area Director	08/10/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G444	A. BUILDING 00 B. WING	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	902 N MUESSING RD INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Developmental Disabilities incident report had not been filed for the client abuse on 05/31/2012. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G444	A. BUILDING 00 B. WING	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	902 N MUESSING RD INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on observation, record review and interview, the facility failed to obtain a physical therapy assessment when recommended for 1 of 3 sampled clients (client #1). Findings include: During observations at the group home on 07/09/2012 between 4:30 p.m. and 7:10 p.m., client #1 did not wear leg braces. During observations at the group home on 07/10/2012 between 6:10 a.m. and 7:40 a.m., client #1 did not wear leg braces. During observations at day services on 07/10/2012 between 8:15 a.m. and 9:20 a.m., client #1 did not wear leg braces. Client #1's record was reviewed on 07/10/2012 at 11:06 a.m. A physical therapy consult, dated 03/15/2010, indicated, client #1 had HKA (Hip-Knee-Ankle) braces. The record indicated, "...Brace fit is less than ideal (symbol for with) belt not snug, (R) (right) knee jt (joint) exterior to hinge and	W0210	The Residential Director was in-serviced on the policy for new admissions on 7/26/12. The Residential Director received training which includes ensuring all new admissions have accurate assessments or reassessments completed within the first 30 days after a new admission moves into the group home. This will be monitored by the Area Director and the program nurse who will ensure that the assessments or reassessments are in place within the first 30 days after admission. An appointment for a physical therapy assessment has been scheduled for client #1. Persons Responsible: Residential Director, Area Director, Program Nurse	08/10/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G444	A. BUILDING 00 B. WING	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	902 N MUESSING RD INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	AFO (Ankle-Foot Orthosis) not making contact on (R) calf. Recommend re-fit...See again in 2 years..." The record did not indicate a physical therapy evaluation had been completed. During an interview on 07/10/2012 at 11:45 a.m., the Director of Health Services (DHS) stated, "Anything that has been done should be in the files," when asked if the physical therapy evaluation had been completed. 9-3-4(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G444	A. BUILDING 00 B. WING	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	902 N MUESSING RD INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation,record review and interview, the interdisciplinary team (IDT) failed to address training needs for 1 of 3 sampled clients (client #1). Findings include: During observations at the group home on 07/09/2012 between 4:30 p.m. and 7:10 p.m., client #1 did not wear leg braces. During observations at the group home on 07/10/2012 between 6:10 a.m. and 7:40 a.m., client #1 did not wear leg braces. During observations at day services on 07/10/2012 between 8:15 a.m. and 9:20 a.m., client #1 did not wear leg braces. Client #1's record was reviewed on 07/10/2012 at 11:06 a.m. A physical therapy consult, dated 03/15/2010, indicated, client #1 had HKA (Hip-Knee-Ankle) braces. The record indicated, "...Brace fit is less than ideal (symbol for with) belt not snug, (R) (right) knee jt (joint) exterior to hinge and AFO (Ankle-Foot Orthosis) not making	W0227	A goal has been created to increase client 1 tolerance of her leg braces. The goal will track her use of and ambulation with her leg braces. See attachment #1. The goal will be routinely reviewed to determine compliance with wearing the leg braces. An appointment for a physical therapy assessment has been scheduled for client # 1 to ensure that her braces fit appropriately. Persons Responsible: Residential Director and Program Nurse	08/10/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G444	A. BUILDING 00 B. WING	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	902 N MUESSING RD INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	contact on (R) calf. Recommend re-fit...See again in 2 years..." An Individual Support Plan (ISP), dated 02/23/2012, did not indicate the Interdisciplinary Team (IDT) met and developed a goal to encourage client #1 to wear her HKA braces. A Behavioral Support Plan (BSP), dated 04/06/2012 did not indicate refusals to wear HKA braces were addressed as a target behavior. During an interview on 07/10/2012 at 11:45 a.m., Area Director (AD) #1 indicated client #1's braces were re-fitted. She indicated client #1 refused to wear the braces. AD #1 stated, "I thought there was an IDT and something in her behavior plan addressing refusals of medical recommendations." 9-3-4(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G444	A. BUILDING 00 B. WING	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	902 N MUESSING RD INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview, the facility failed to obtain a recommended PAP (screening test to detect potentially pre-cancerous processes in the endocervical canal) when recommended for 1 of 3 sampled clients (client #1). Findings include: Client #1's record was reviewed on 07/10/2012 at 11:06 a.m. A physical, dated 02/24/2012, indicated, "...Will defer PAP/pelvic to May 2012...." The record did not indicated a PAP was completed. During an interview on 07/10/2012 at 11:45 a.m., the Director of Health Services (DHS) stated, "Anything that has been done should be in the files," when asked if the PAP smear had been completed. 9-3-6(a)	W0322	Client #1 has completed her PAP/pelvic on 7/12/12. See attachment #2. The program nurse will keep a record of consumer appointments which will include recommended dates for follow up appointments. See attachment #3.Persons Responsible: Program Nurse	08/10/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G444	A. BUILDING 00 B. WING	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	902 N MUESSING RD INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview, the facility failed to ensure nursing services followed up on physician recommendations and failed to revise health risk plans/protocols when needed. The facility nursing services failed to ensure physician orders were correctly implemented and/or clarified and failed to ensure dietary recommendations were followed for 2 of 3 sampled clients (clients #1 and #4). Findings include: 1. During observations at the group home on 07/09/2012 between 4:30 p.m. and 7:10 p.m., client #1 did not wear leg braces. Client #1 received 1 can of Ensure (dietary supplement) with her dinner. During observations on 07/09/2012 at 5:00 p.m., the House Manager(HM) filled a barrel syringe with 50 cc (cubic centimeters) of sterile water and handed the syringe to client #1. Client #1 irrigated her suprapubic catheter (tube inserted into the bladder through a surgically created opening through the abdominal wall) with the sterile water and	W0331	Client #1 Medication Administration Record has been revised to reflect the prescribed Ensure twice daily. The Dining Plan has been revised to reflect this change as well. See attachment # 4. The Medication Administration Record has also been revised to reflect the prescribed order to irrigate Client #1's catheter with 100cc of sterile water. See attachment #5. The PAP/pelvic has been completed for Client #1 on 7/12/12. Staff have received retraining on appropriate snack choices and serving size for client #4. Additionally, training was received on the importance of following the posted menus for each client. Routine observations will be complete to ensure that meals and snacks follow the posted menus. Persons Responsible: Program Nurse and Residential Director	08/10/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G444	A. BUILDING 00 B. WING	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	902 N MUESSING RD INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	handed the empty syringe to the HM. The HM placed another 50 cc of sterile water into the syringe and handed it to client #1 who used the contents to complete a second suprapubic catheter flush. During observations at the group home on 07/10/2012 between 6:10 a.m. and 7:40 a.m., client #1 did not wear leg braces. Client #1 received 1 can of Ensure with her breakfast. During observations at day services on 07/10/2012 between 8:15 a.m. and 9:20 a.m., client #1 did not wear leg braces. Client #1's record was reviewed on 07/10/2012 at 11:06 a.m. The physician's orders, dated 07/01/2012-07/31/2012, indicated, "...STERILE WATER CIRRI 1000 ML (milliliter) IRRIGATE CATH (catheter) 3 TIMES A DAY W/(with) 100 ML.... REGULAR DIET....IRRIGATE CATHETER W/10 CC OF STERILE WATER 2 TIMES DAILY-PT(patient) TO DO W/STAFF SUPERVISION...." An undated protocol, titled, "Protocol for [client #1's] enema and urine catheterization" indicated, "...[Client #1] has an indwelling suprapubic catheter. She is to irrigate this twice a day with sterile normal saline. This is done once in the morning and once in the evening...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G444	A. BUILDING 00 B. WING	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	902 N MUESSING RD INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The record did not indicate a physician order clarifying the irrigation solution and amount was obtained. A physical, dated 02/24/2012, indicated, "...Will defer PAP/pelvic to May 2012...." The record did not indicated a PAP was completed. A physical therapy consult, dated 03/15/2010, indicated, client #1 had HKA (Hip-Knee-Ankle) braces. The record indicated, "...Brace fit is less than ideal (symbol for with) belt not snug, (R) (right) knee jt (joint) exterior to hinge and AFO (Ankle-Foot Orthosis) not making contact on (R) calf. Recommend re-fit...See again in 2 years..." The record did not indicate a physical therapy evaluation had been completed. A "NURSING QUARTERLY REVIEW," dated April (no day) 2012, indicated, "...NCS (no concentrated sweets), NAS (no added salt), low fat, low chol (cholesterol) diet...." A "Quarterly Nutritional Review," dated 05/15/2012, indicated,'...Current Diet Order: regular...Food Supplements: CIB (Carnation Instant Breakfast)...." A "Dining Plan," dated May (no day) 2012, indicated client #1 was on a regular			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G444	A. BUILDING 00 B. WING	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	902 N MUESSING RD INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	diet. The dining plan indicated, "...Carnation Instant Breakfast in 8 ounces milk 2 times a day after eating breakfast and dinner...." During an interview on 07/09/2012 at 5:00 p.m., the HM indicated the suprapubic catheter was flushed 3 times a day with 100 cc of sterile water. During an interview on 07/10/2012 at 11:45 a.m., the Director of Health Services (DHS) stated, "Anything that has been done should be in the files," when asked if the physical therapy evaluation or PAP had been completed. She indicated it was the nurse's responsibility to ensure the catheter irrigation protocol and physician orders were clarified and revised. The DHS indicated CIB should have been used as the dietary supplement. 2. During observations on 07/09/2012 at 4:40 p.m., client #4 poured herself an 8 ounce glass of skim milk. She had a snack of cheese puffed popcorn. Client #4 placed a piece of paper toweling on the dining table and placed a heaping pile of puffed popcorn onto the paper towel. The snack was piled 4 inches high and covered the entire piece of paper towel. Client #4 ate the snack, the obtained a second snack of the same food item, serving herself a similar portion size. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G444	A. BUILDING 00 B. WING	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	902 N MUESSING RD INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	14 ounce snack bag was full prior to client #4 obtaining her snack. After she obtained the snacks, the bag was only 1/4 full. Staff were not present in the dining area while client #4 ate her snack. The week 3 "SPRING/SUMMER MENU-LOW FAT, LOW CHOLESTEROL, NO CONCENTRATED SWEETS," indicated, "...HS SNAX (bedtime snack) 8 to 12 oz(ounces) SF (sugar free) Punch, 1/2 c (cup) Pineapple-in own juice...." Client #4's record was reviewed on 07/10/2012 at 12:35 p.m. Diagnoses included, but were not limited to high cholesterol and diabetes mellitus. Physician's orders, dated 07/01-07/31/2012, indicated, "...LOW FAT, LOW CHOL (cholesterol) NO CONCENTRATED SWEETS, NO ADDED SALT, SINGLE SERVING (diet)...." A Dining Plan, dated March 2012, indicated, "...DIET ORDER: Low fat, low cholesterol, NCS, No added salts...Single servings. Follow written menu...Serve evening snack as per menu. Discourage between meal snacking such as chips... [Client #4] is to be supervised with meals...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G444	A. BUILDING 00 B. WING	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	902 N MUESSING RD INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 07/09/2012 at 6:40 p.m., the Qualified Developmental Disabilities Professional Designee (QDDP-D) indicated clients receive low fat snacks after work. She stated, "It is a reflections time where clients relax and talk about their day." She stated, "The dietitian observed the reflection time and did not comment on the snacks." During an interview on 07/10/2012 at 1:40 p.m., the Director of Health Services (DHS) indicated client #4 should have received the diet ordered. 9-3-6(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G444	A. BUILDING 00 B. WING	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	902 N MUESSING RD INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on interview and record review, the facility failed to ensure quarterly nursing assessments for 2 of 3 sampled clients (clients #2 and #4). Findings include: 1. Client #2's record was reviewed on 7/10/2012 at 10:05 a.m. The record indicated quarterly nursing assessments were completed, August (no day) 2011, December (no day) 2011, and April (no day), 2012. 2. Client #4's record was reviewed on 07/10/2012 at 12:35 p.m. The record indicated quarterly nursing assessments were completed, August (no day) 2011, December (no day) 2011, and April (no day), 2012. During an interview on 07/10/2012 at 1:25 p.m., the Director of Health Services indicated the nurse should have included a day of the month that the nursing evaluations were completed. She indicated the assessments should have occurred quarterly.	W0336	The Program Nurse has received retraining to ensure that quarterly nursing assessments are completed on a quarterly basis. The retraining also includes the necessity to include the full date on each quarterly assessment. This training occurred on 7/25/12. The quarterly nursing assessments will be reviewed routinely by the Health Services Director to ensure completion within the correct time frame. Persons Responsible: Program Nurse and Health Services Director	08/10/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G444	A. BUILDING 00 B. WING	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	902 N MUESSING RD INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	9-3-6(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G444	A. BUILDING 00 B. WING	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	902 N MUESSING RD INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to ensure an evacuation drill was conducted quarterly for each shift for 3 of 3 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5, and #6). Findings include: The facility's evacuation drills were reviewed on 07/09/2012 at 1:55 p.m. Records indicated a drill was not completed during the day shift (6 a.m.-4 p.m.) for the quarters covering January, February, March, 2012, and April, May, and June, 2012. Records indicated a drill was not completed on the night shift (10 p.m.-6 a.m.) for the quarter covering January, February, March, 2012. The record did not indicate fire drill was completed on any shift for the quarter covering October, November, December, 2011. During an interview on 07/09/2012 at 1:30 p.m., Residential Director (RD) #1 indicated the facility did not conduct fire drills quarterly on each shift. 9-3-7(a)	W0440	Staff have been in-serviced on completing drills in compliance with regulations. This training occurred on 7/19/12. The Residential Director will be responsible to schedule specific staff to complete drills at a frequency which is compliant with regulations. See attachment #6. This schedule will be placed in the site. The drills and schedule will be monitored by the Residential Director and Area Director to assure compliance. Additionally, clerical staff will track the completion of the drills and provide periodic reports to the Residential Director and Area Director who will assure compliance.Person responsible: Residential Director and Area Director	08/10/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G444	A. BUILDING 00 B. WING	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	902 N MUESSING RD INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE